Arizona

Department of **E**conomic **S**ecurity

Member Handbook

Arizona
Long Term Care System
(ALTCS)

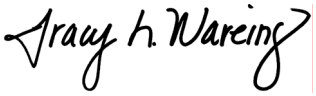
Dear Member

Welcome to the Arizona Long Term Care System (ALTCS). As a member, you are qualified to receive services that are authorized by and funded through Title XIX (Medicaid) of the Social Security Act.

ALTCS services will be provided to you through the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). We are dedicated to working with you and your family to support meaningful choices that promote self-sufficiency, community involvement and health maintenance.

How the system works and what services are available are explained in this handbook. If you have any questions or need additional information, please contact your support coordinator or your local DES/DDD office. Locations and telephone numbers are listed on page 16 of this handbook.

Sincerely,



Tracy L. Wareing
Director
Department of Economic Security (DES)

Barbara Brent
Assistant Director (DES)
Division of Developmental Disabilities (DDD)

Equal Opportunity Employer/Program ◆ Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602 542-6825; TTY/TDD Services: 7-1-1.

All applicants for services and/or program participation have a right to file complaints and to appeal according to regulations by notifying:

Arizona Department of Economic Security
Director's Office of Equal Opportunity
1717 W. Jefferson Street, Room 109
Phoenix, AZ 85007
Voice: 602-364-3976 or TTY/TDD Services 7-1-1

Your Support Coordinator

Name_____

Phone Number_____

Table of Contents

General Information 1

Managed Care 3

Service Delivery 4

Health and Medical Services 8

Emergency Care 10

Rights and Responsibilities 10

Fraud and Abuse 11

Mediation 11

Appeals and Requests for Fair Hearing 13

Acronyms/Abbreviations 15

Service Offices 16

GENERAL INFORMATION

What is ALTCS?

ALTCS is the Arizona Long Term Care System that provides acute and long-term care services under federal guidelines and federal funds.

The federal Medicaid Program contracts with the Arizona Health Care Cost Containment System (AHCCCS) to provide a managed care system, part of which is ALTCS. AHCCCS in turn contracts with the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) to deliver ALTCS services for eligible people with developmental disabilities. DES/DDD will be referred to as the Division throughout this booklet.

Who determines ALTCS eligibility?

AHCCCS determines eligibility based on your finances and on your medical and functional status. Continued eligibility is reviewed and determined by AHCCCS.

What happens after ALTCS eligibility is determined?

AHCCCS notifies us, the Division. Then a Division support coordinator will contact you as the member or your responsible party. One of the first things that need to be done is to enroll with a health plan if a choice is available in your county and choose a primary care physician. Please note that if you move after your enroll, you may have to change health plans and/or physicians. The support coordinator will help you with this. The support coordinator will schedule a face-to-face meeting with you to answer questions, help you understand the system, explain your rights and develop your service plan.

What is a Primary Care Physician?

A Primary Care Physician (PCP) is your health plan physician. The PCP approves your medical care, makes referrals to specialists and orders certain services such as therapy, home health nursing or home health aide, etc.

How do I get a Primary Care Physician?

Your support coordinator will contact you once you are enrolled in ALTCS. Once you choose a health plan, you will need to choose a PCP. If you do not choose a PCP within 10 calendar days, the health plan will assign one for you. You can request a change of PCP by contacting your health plan member services representative.

How do I get to see my PCP?

Call your physician's office. Please refer to your "Health Plan Member Handbook" or your "Fee for Service Handbook" for further information.

How do I make, change and/or cancel an appointment with my PCP?

Schedule appointments hours when possible instead of using urgent care or the emergency room. Keep appointments and arrive on time. Call your PCP's office ahead of time when you cannot keep your appointments.

What if I want to see a physician that is not on the health plan?

The choice of physicians is yours, but if you use a physician that is not on the ALTCS health plan, you will be responsible for costs. If you have private health insurance, including Medicare, check on the plan's coverage for medical costs.

Is there any charge for ALTCS services?

For residents of an institution or a nursing facility, you will pay a share of cost, if you have an income. Any share of cost is determined by AHCCCS based on their criteria.

For situations where there is private insurance or other health insurance, those insurance benefits must pay first before ALTCS money is used. ALTCS is the payor of last resort.

What if I move out of state/out of the country?

Health care services are limited to emergency care only when you are out of state temporarily (less than 60 days). Health care coverage is not available when you are out of the country.

Health and long term care services through the ALTCS Division are limited to residents of the state of Arizona. If you are thinking about moving out of state or out of country, contact your support coordinator. He/she can provide assistance in locating services and resources for the area where you are moving. Keep in mind that eligibility requirements and covered services may vary from state to state.

If I qualify, can I use Medicare for my medical insurance?

Yes, Medicare is medical insurance. If you are using Medicare as your medical insurance, you may receive additional services. Refer to your "Medicare and You" handbook. Call 1-800-MEDICARE (1-800-633-4227) for a copy or go online to www.Medicare.gov. Be sure to let your health care providers and your support coordinator know if you have Medicare.

As of January 1, 2006, if you are ALTCS eligible and have Medicare, most of your prescription drugs will be covered through your Medicare Advantage or Medicare Prescription Drug Plan. There may be a small co-payment for each prescription. There are certain medications that will continue to be covered by your ALTCS Health Plan or through the Regional Behavioral Health Authority.

What is the transitional ALTCS Program?

Even if you do not functionally qualify for ALTCS, you may still qualify for services through the transitional ALTCS program. AHCCCS also determines eligibility for this program. If you are eligible for the transitional ALTCS Program, you may receive the services listed in this booklet; however, there is a limitation on services received in institutional settings (e.g. Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, etc.)

MANAGED CARE

What is Managed Care?

Managed Care is a system of health care. A managed care organization is usually called a health plan. Health plans contract with a group of health care providers such as physicians, hospitals, clinics, therapists, pharmacies and others.

Is there an incentive plan for physicians?

Federal law allows health plans to provide incentive plans for physicians. This means "any compensation arrangement between a Managed Care Organization (health plan) and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare beneficiaries or Medicaid recipients enrolled in the Managed Care Organization."

If you want to know what incentive plans your physician has or any of the contract terms, you may request this information. For example, you may request:

- Whether your health plan has physician incentive plans that affect the use of referral services;
- The type of compensation arrangements the plan uses, e.g., bonus, withholding;
- Whether stop-loss insurance is provided to the physician incentive plan; and
- A summary of any member survey results.

Contact your health plan, at the number noted in your "Health Plan Member Handbook", to obtain the above information.

No specific payment of any kind may be made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit covered medically necessary services furnished to a member.

See your
"Health Plan Member Handbook"
for information and phone numbers.

SERVICE DELIVERY

What does a support coordinator do?

Support coordinators assess and coordinate your service needs. They work with you to arrange for services and to assist in identifying appropriate community resources. In addition, they monitor how your services are provided.

Can I receive any services that are long-term care services?

Services must be medically appropriate, necessary, cost-effective and authorized. You have the right to receive services as authorized. Many of the long-term care services can be provided in your home.

What residential options may be available?

The Division provides services in a variety of community living environments. Some residential opportunities may be available for individuals to choose from that are aided by supports put in place within their communities. These services are not an entitlement or right. Options include:

- Adult Developmental Home: An alternative residential setting for individuals 18 years or older. This setting provides room and board, supervision and coordination of habilitation for up to three people.

- Child Developmental Foster Home: An alternative residential setting for children under 18 years. This setting provides supervision and coordination of habilitation for up to three children. ALTCS covers services except for room and board.

- Group Home: A community residential setting for up to six people. It is licensed by Department of Health Services to provide room and board, supervision and habilitation. The Group Home provides a safe, homelike, family atmosphere, which meets the physical and emotional needs of individuals who cannot physically or functionally live independently in the community. ALTCS covers services except for room and board.

- Nursing Facility: A Medicare/Medicaid facility that provides inpatient room and board and nursing services to individuals who require these services on a continuous basis, but who do not require hospital care or direct daily care from a physician.

- Intermediate Care Facility for the Mentally Retarded (ICR/MR): A facility that provides health, habilitative and rehabilitative services to individuals who require services on a continuous basis.

Who will provide these services?

The Division will coordinate with an individual or an agency to provide services. You can choose a provider, if a choice is available. Call your support coordinator if you would like a copy of a provider directory for your area and a listing of providers who speak languages other than English.

The behavioral health services are provided through Regional Behavioral Health Authorities (RBHAs). Your support coordinator can let you know who serves your area.

Can any therapist or provider deliver ALTCS services?

No, all service providers must be certified by DES/Office of Licensing, Certification and Regulation and registered with AHCCCS. They must have a contract or individual provider agreement with the Division. A therapist must maintain the appropriate and current professional license.

What long-term services are covered?

You and your support coordinator will review all of your current evaluations to assess your needs. From this review, your Individual Support Plan (ISP) will be developed. Your support coordinator will coordinate services based on your ISP. The ISP will be reviewed regularly and can be changed as needed. Based upon medical need and within the Division rules, you may be authorized to receive one or more of the following services:

- Attendant Care (help with personal care and housekeeping);
- Augmentative Communication (devices to help in communication);
- Behavioral Health (care for individuals with behavioral health needs);
- Day Treatment and Training (training, supervision and therapeutic activities to promote skill development in independent living, self care, communication and social relationships);
- Extended Employment Services (provides training and ongoing supports to persons engaged in work);
- *Home modification (building modifications to allow individuals to function as independently as possible in their own home);
- Habilitation (interventions such as habilitative therapies, special developmental skills, behavior intervention and sensory-motor development designed to increase functioning);
- *Home Health Aide (health maintenance, continued treatment or monitoring of a health condition and supportive care with activities of daily living);
- *Home Health Nurse (skilled nursing services);
- Homemaker (help with housecleaning);
- *Hospice (care for terminally ill individuals);
- Non-Emergency Transportation (must be medically necessary and to or from another ALTCS service);
- Respite (short term care and supervision to relieve the caregiver); and/or
- Support Coordination (coordination of services).

*These services must be prior authorized by your Primary Care Physician (PCP).

What long-term care services are not covered?

All long-term care services must be authorized before they are provided. Any services not authorized are not covered.

What behavioral health services are covered?

Your support coordinator can answer your questions and provide information about behavioral health services. The following behavioral health services are covered:

- Behavior Management (behavioral health personal assistance, family support, peer support)
- Behavioral Health Case Management Services
- Behavioral Health Nursing Services
- Emergency/Crisis Behavioral Health Care
- Emergency and Non-Emergency Transportation
- Evaluation and Assessment
- Group Therapy and Counseling
- Individual Therapy and Counseling
- Family Therapy and Counseling
- Inpatient Hospital Services
- Non-Hospital Inpatient Psychiatric Facilities (residential treatment centers and sub-acute facilities)
- Institutions for Mental Disease (with limitations)
- Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
- Opoid Againt Treatment
- Partial Care (supervised day program, therapeutic day program and medical day program)
- Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching and employment support)
- Psychotropic Medication
- Psychotropic Medication Adjustment and Monitoring
- Respite Care (with limitations)
- Rural Substance Abuse Transitional Agency Services
- Screening
- Therapeutic Foster Care

How do I get behavioral health services?

You may apply on your own or seek assistance from your support coordinator or primary care physician. The Regional Behavioral Health Authority (RBHA) will determine which behavioral health services you will receive.

Questions ??
Contact your Support Coordinator

How do I contact the Regional Behavioral Health Authority (RBHA) that serves my county?

If you have questions regarding behavioral health services, call your local RBHA. The names and telephone numbers of the local RBHA's are:

- Value Options (Maricopa County)
  - ✓ Information & Referral toll-free 800-564-5465
  - ✓ Crisis Phone Line 602-222-9444 toll-free 800-631-1314
- Community Partnerships of Southern Arizona
  (Cochise, Graham, Greenlee, Pima, & Santa Cruz Counties)
  - ✓ Information & Referral 520-318-6946 o toll-free 800-771-9889
  - ✓ Crisis Phone Line 520-662-6000 or toll-free 800-796-6762 (Pima County)
    800-586-9161 (Cochise, Graham, Greenlee, and Santa Cruz Counties)
- Northern Arizona Regional Behavioral Health Authority
  (Apache, Coconino, Mohave, Navajo, and Yavapai Counties)
  - ✓ Information & Referral 928-774-2070 and toll-free 800-640-2123
  - ✓ Crisis Phone Line toll-free 877-756-4090
- Cenpatico Behavioral Health of Arizona (Gila, La Paz, Pinal and Yuma Counties)
  - ✓ Information & Referral 480-982-1317 or toll-free 800-982-1317
  - ✓ Crisis Phone Line toll-free 800-982-1317

What if this is an emergency?

If you are in a crisis situation and think you might hurt yourself or someone else, please call 911 or the Crisis Phone Line listed above for your local RBHA.

HEALTH AND MEDICAL SERVICES

What are health and medical services?

Health and medical services are also known as acute care services that either maintain or restore good health. The services must be medically necessary and cost effective. They are provided through your Primary Care Physician (PCP). Your PCP may refer you to a specialist, if appropriate. Contact your Division support coordinator if you need assistance in coordinating care and services. There may be exclusions or limitations on some services depending upon whether you are over 21 years of age. Your "Health Plan Member Handbook" or your "Fee for Service Handbook" will tell you more about each service noted below.

- Ambulatory Surgery and Anesthesiology
- Anti-hemophilic Agents and Related Services
- Audiology
- Behavioral Health
- Chiropractic Services
- Dental
- Dialysis
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Emergency Services
- Eye Examinations/Optometry
- Family Planning
- Health Risk Assessment and Screening
- Hospital Services
- Immunizations
- Laboratory
- Maternity Services
- Medical Foods
- Medically-Necessary Abortions
- Medical Supplies, Durable Medical Equipment (DME), Orthotic and Prosthetic Devices
- Nutrition
- Physician Services
- Podiatry
- Post Stabilization Care Services
- Prescription Medications and Pharmacy
- Preventive and Prenatal HIV Testing and Counseling
- Primary Care Physician (PCP) Services
- Radiology and Medical Imaging
- Rehabilitation Therapy
- Respiratory Therapy
- Transplantation of Organs and Tissue and Related Immunosuppressant Drugs
- Transportation
- Triage/Screening and Evaluation

What is EPSDT?

Early and Periodic Screening, Diagnosis and Treatment This program provides comprehensive health care service through primary prevention, early intervention, diagnosis and medically necessary treatment from birth to age 21. Included are a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screening and immunizations. EPSDT provides for all medically necessary services to treat a physical or mental illness discovered in the process.

What if I am eligible for Children Rehabilitation Services (CRS)?

If you are eligible, you will be referred to these services before you use services provided by the Division or your health plan.

Do I have to go through my PCP for all services?

Yes, except for behavioral health services, dental services and transportation. If you are under 21 years of age, you may use dental services directly from a dentist. Check with your health plan for coverage and a list of available dentists. If you need transportation to a medical appointment, please refer to your "Health Plan Member Handbook" or "Fee for Service Handbook."

You can get behavioral health services at your local Regional Behavioral Health Authority (RBHA). You do not need a referral from your PCP for behavioral health services. However, your PCP may be able to help you if you have depression, anxiety or attention deficit disorder.

What services are not covered?

Some services not covered are:

- Cosmetic Surgery (surgery to change the way you look);
- Prescription and Medical Supplies not ordered by your physician;
- Hearing Aids and Eyeglasses for adults; or
- Services from Private Physicians or Hospitals that were not approved by your physician.

What are Advance Directives?

You have the right to participate in decisions regarding your health care. There may be a time, however, when you are so ill that you cannot make decisions about your health care. If this happens, advance directives are documents that protect your right to refuse health care you do not want or to request care you do want.

There are four types of Advance Directives: a Living Will, a Medical Power of Attorney, a Mental Health Care Power of Attorney and a Pre-Hospital Medical Directive. Refer to your "Health Plan Member Handbook" for further information regarding these documents.

You should get help writing Advance Directives. Ask your doctor for help if you are not sure whom to call. Please refer to your "Health Plan Member Handbook" for further information regarding these documents.

EMERGENCY CARE

What do I do in case of an emergency?

Emergency care is available 24 hours a day, 7 days a week. If you need emergency care, call your physician or the number in your "Health Plan Member Handbook" for information on what to do and where to go for care. If it is a life-threatening emergency, call 911 or the emergency number for your area.

Emergency services are those health services that are required for relief of severe pain or treatment of a sudden medical condition which if not immediately treated, would lead to a disability or death. Minor problems such as flu, colds, sore throats, etc., are not emergencies. Hospital emergency rooms should be used for life threatening situations only.

For further information, see your "Health Plan Member Handbook".

RIGHTS AND RESPONSIBILITIES

What are my rights?

Your support coordinator will give you a list of your rights and explain them to you.

What are my rights to services?

You will receive the services listed in your Individual Support Plan (ISP). Services must be medically necessary, cost effective and based on actual needs as shown by assessments.

You have the right to know about providers who speak languages other than English.

You can get covered services without concern about race, ethnicity, national origin, religion, gender, age or ability to pay.

You can get quality services that support your personal beliefs, medical condition and background in a language you understand.

You can get interpreter services if you do not speak English or if you are hearing impaired, to help you get the services you need.

You have the right to Advance Directives and information on how to make medical decisions made for you if you are not able to make them for yourself.

You can receive information on available treatment options and alternatives that are presented in a manner appropriate to your condition and your ability to understand.

You, if you are female, may have direct access to preventative and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.

You may get a second opinion from a qualified health care professional within the network, or have a second opinion arranged outside the network, only if there is not adequate in-network coverage, at no cost to you.

You have the right to receive all critical services identified in your Individual Support Plan to help with bathing, dressing, toileting, feeding, transferring to and from your bed or wheelchair and other similar daily activities.

You also have the right to participate in developing a back-up plan for any critical service provided in your home. This back-up plan will include steps and resources available to you when unplanned circumstances occur (e.g. regular caregiver is ill and unable to provide scheduled services). You may also call your Support Coordinator to help you receive these critical services.

What are my responsibilities?

You must tell your support coordinator if your finances change and about any health insurance you have.

You are responsible for keeping your AHCCCS identification card. When it is not valid, it is your responsibility to destroy it. Any misuse of the card, including loaning, selling or giving it to others could result in loss of your eligibility as a member and/or in legal action.

Who has the right to see my records?

All information and records are confidential. They may be shown only with written consent from you or your responsible person, unless otherwise stated by law. You may review your records at any time. You also have a right to receive a copy of your medical records free of charge.

FRAUD AND ABUSE

Your ALTCS benefits are provided based on your health and financial status. Your benefits may not be used by anyone else. Do not loan your health care card to anyone. If your card is lost or stolen, report it immediately to your support coordinator at the number noted inside the front cover of this handbook.

If you notice things like a provider billing for services you have not received or someone getting ALTCS benefits for which they are not eligible, you must report this to your support coordinator.

If you commit fraud, you may lose your benefits and legal action against you may be taken.

MEDIATION

What is mediation?

Mediation is a process for resolving disagreements without a grievance and appeal process. It is an informal process involving a mediator.

What is the mediator's role?

Mediators are trained neutral volunteers who help define issues and guide the communication process so that a mutual agreement can be reached. The mediator may offer suggestions and help develop options to resolve issues, but the participants make the final agreement. In order for mediation to be effective, all participants must want to resolve the issues and be willing to work toward that goal.

Is mediation confidential?

Yes, the mediators and participants will not disclose information from the mediation meeting.

Do I need a lawyer?

Mediation is not a substitute for legal advice. If you retain a lawyer, be advised that your lawyer may not directly participate in mediation.

How long does mediation take?

Mediation meetings are normally two hours in length and may range from one to three sessions, depending on the complexity of the issues.

What is a mediation agreement?

When participants agree on a solution, an agreement is written by the mediators and signed by all participants. The agreement is a written plan of action where each party has clearly defined the steps necessary to resolve the conflict. Mediation agreements are typically more creative and mutually acceptable than a finding made by a grievance or a hearing officer.

How do I request mediation?

Inform your support coordinator, or call the Division mediation coordinator at 602-542-0419, outside of Maricopa county call toll-free 866-229-5553, or call the Arizona Attorney General Community Relations Section at 602-542-4192.

APPEALS AND REQUESTS FOR FAIR HEARING

If you want to appeal a decision regarding the denial, suspension, reduction or termination of your services, you must request this appeal no later than 60 calendar days from the date of the written notice you received advising you of the action.

What is a Notice?

An "Action" by the Division of Developmental Disabilities means:

- The denial or limited authorization of a service you have requested, including the type and level of service;
- The reduction, suspension, or termination of an existing service;
- The denial of payment for a service, either all or in part;
- The failure to provide services in a timely manner;
- The failure to act within certain timeframes for grievances and appeals;
- The denial to obtain a health care service outside the Division's network if you live in a rural area.

How do I request an appeal?

If you or people acting on your behalf, including your doctor or provider, disagree with the Division's action, you may file an appeal. You may do this by calling the Division's Office of Compliance and Review at 602-542-0419 or outside of Maricopa County call toll-free 866-229-5553 and present your appeal orally.

Will my services continue during the appeal process?

You are entitled to continue receiving services during the appeal process if:

1) Your appeal involves a termination or reduction of the service you are currently receiving;
2) The service you are receiving was ordered by a provider;
3) The original authorization for the service you are receiving has not expired;
4) You request that the service continue; and
5) You file the appeal before the intended date of reduction/termination, or you request the appeal within ten days of the mailing of the notice, whichever is later.

How long will my services continue?

You will continue to receive your services until any one of the following occurs:

1) You withdraw the appeal;
2) You do not request a hearing 10 days from the date the Division sent you the appeal decision or do not request that the services continue when you are requesting a hearing;
3) AHCCCS issues a hearing decision against you; or
4) The time limits of a service authorization have been met.

How long will the appeal process take?

The Division will investigate the appeal and make a final written decision within 30 calendar days. If the Division needs additional investigation time, you will be asked for an extension.

Can I request a faster review of my appeal?

You may ask for a faster review of your appeal if your life or health could be in danger, or your ability to attain, maintain or regain maximum function would be damaged by waiting the normal 30 days for a decision on your appeal. This is called an "expedited appeal". If your health care provider tells us this, the appeal will be decided in three days. You may also ask the Division to decide the appeal in three working days. If you ask the Division yourself and the Division agrees, a decision will be made in three working days. If the Division does not agree that a faster review is needed, you will receive a letter in two days and the Division will try to call you regarding this. The decision regarding your appeal will then be made in 30 days.

What if I disagree with this decision?

You may request that AHCCCS hold a formal hearing on the matter where AHCCCS will make the final decision about your appeal. You must file a written request for a hearing with the Division's Office of Compliance and Review within 30 calendar days of the postmark date of the Division's appeal decision. If after the hearing AHCCCS decides that the Division's decision was correct, you will be responsible for payment of the services you received while your appeal was being reviewed.

If you do no receive a written appeal decision from the Division within 30 calendar days, you have the right to file a request for a hearing with AHCCCS.

What do I have to say in my request for a hearing with AHCCCS?

The written request for a hearing must state the issue that is being appealed to AHCCCS.

Acronyms Confusing??
See the list on Page 15

ACRONYMS/ABBREVIATIONS

AHCCCS Arizona Health Care Cost Containment System - This agency administers Arizona's Medical programs.

ALTCS Arizona Long Term Care System - This program is administered by AHCCCS and provides long term and acute medical services to eligible individuals based on documented needs.

DES Department of Economic Security - This is the State agency overseeing the Division of Developmental Disabilities.

DIVISION Division of Developmental Disabilities - The division of DES that is responsible for providing services to ALTCS eligible individuals who have a developmental disability.

DME Durable Medical Equipment - This necessary equipment is used over time and is not thrown away such as wheelchairs, ventilators, braces, etc.

EPSDT Early and Periodic Screening, Diagnosis and Treatment - The Division provides these comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment.

ISP Individual Support Plan. This is a process that includes a review of assessments and evaluations; determination of services needed; setting of goals and objectives and development of strategies to meet those objectives. A team including the person supported, responsible person, support coordinator and others develop, as appropriate, the ISP. This plan guides service delivery and includes a process for monitoring the quality and effectiveness of services.

MEDICAID See TITLE XIX.

PCP Primary Care Physician - This is the physician who is responsible for all the health needs of the individual. The PCP orders certain services and refers individuals to specialists.

TITLE XIX This is a section of the Social Security Act created in 1965. It helps states in providing medical and long term care services to individuals who are blind, have a disability or are age 65 or older that meet certain income requirements.

SERVICE OFFICES

For information, call the service office nearest you.

District I
4000 North Central Ave, Suite #900
Phoenix, Arizona 85012
(602) 246-0546
Toll Free 800-749-9400

District II
400 West Congress, Suite #500
Tucson, Arizona 85701
(520) 628-6800
Toll Free: 877-739-3943

District III
2705 North 4th Street, Suite A
Flagstaff, Arizona 86004
(528) 773-4957
Toll Free: 888-289-2003, Prescott
888-289-7177, Flagstaff
866-283-4520, Tuba City
866-560-8325, Chinle
800-770-6493, Window Rock
888-537-8013, Show Low
800-770-6493, Kayenta

District IV
350 West 16th Street, Suite #232
Yuma, Arizona 85364
(520) 782-4343
Toll Free: 877-739-3922

District V
110 S. Idaho Rd, Ste 240
Apache Junction, Arizona 85219
(480) 982-0018
Toll Free: 877-739-3926, Apache Junction
877-227-1100, Globe

AZ Training Program
2800 North Highway 8
P.O. Box 1467
Coolidge, Arizona 85228
(520) 723-4151
Toll Free: 877-739-3941

District VI
209 Bisbee Road
Bisbee, Arizona 85603
(520) 432-5703 extension 5625
Toll Free: 877-739-3938 ext. 5625

Health Care Services
220 North Central Ave., Suite 207
Phoenix, AZ 85004
Toll Free: 800-624-4964

Division of Developmental Disabilities
Central Office – 791A
1789 W. Jefferson – 4th floor
Phoenix, AZ 85007
(602) 542-0419
Toll-free: 866-229-5553